STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000419	A. BUILDING: _____ B. WING _____	06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER HEALTH CARE & REHABILITATION CENTER	359 RANDOLPH ST PARKER CITY, IN 47368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Licensure Survey. Survey dates: June 19, 20, 23, 24, 25, and 26, 2014. Facility number: 000419 Provider number: 155489 Aim number: 100273190 Survey team: Karen Lewis, RN, TC (June 19, 20, 23, 24, and 26, 2014) Tina Smith-Staats, RN Toni Maley, BSW Ginger McNamee, RN Census bed type: SNF: 8 SNF/NF: 66 Residential: 7 Total: 81 Census Payor type: Medicare: 11 Medicaid: 44 Other: 26 Total: 81 Sample: 7 Parker Health Care and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.	R 000		